Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Corridor Medical Clinic

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-13-2462-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
May 28, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the carrier states that the nurse practitioner is unable to assign and sign a work status report. This is an incorrect denial as well because the nurse practitioner was the acting treating physician."

Amount in Dispute: $15.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Office will be maintaining the denial for charges 99080-73 pursuant to Rule §129.5(a)(b) which states: (1) the term "doctor' means either the treating doctor or a referral doctor, as defined by §133.4 of the title (relating to Consulting and Referral Doctors) (b) The *doctor* shall file a Work Status Report in the form and manner prescribed by the Commission."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 4, 2012	99080	$15.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 sets out guidelines for Work Status Reports
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 193 – Original payment decision is being maintained
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.

Issues

1. Did the requestor support the disputed services are eligible for payment?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, "B7 – "This provider was not certified/eligible to be paid for this procedure/service on this date of service." 28 Texas Labor Code §129.5(b) states in pertinent part, "The doctor shall file a Work Status Report in the form and manner prescribed by the Commission." Review of the submitted documentation finds the carrier's denial is supported.
2. Requirements of Division rules not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.